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Pepperdine University  
Graduate School of Education and Psychology

EXAMINING THERAPISTS' PERCEPTIONS OF STRATEGIES FOR OVERCOMING  
BARRIERS TO TREATMENT WITH YOUTH AND THEIR FAMILIES

A clinical dissertation presented in partial satisfaction  
of the requirements for the degree of  
Doctor of Psychology

by

Lyndsay Brooks

October, 2015

Judy Ho, Ph.D., ABPP – Dissertation Chairperson

This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirement of the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

Youth who are untreated for mental health problems are at risk for a number of consequences, including academic underachievement, substance use, delinquency, and future mental illness in adulthood. Nearly 80% of youth who need mental health services do not receive them, and of those children and families referred, it is estimated that between 30 and 80% terminate from therapy prematurely. Some common barriers to treatment retention for youth clients and families have been identified in the literature, including financial barriers, transportation and other logistical barriers, as well as therapeutic barriers, such as poor therapeutic alliance. Therefore, it is imperative to identify the most commonly used strategies for effectively overcoming barriers to treatment for youth clients and families. In order to gain a clearer understanding of common strategies being utilized to overcome barriers in treatment-as-usual settings, a qualitative examination was conducted with 36 mental health providers to determine the strategies they used with their youth and family clients. Qualitative data analysis procedures based on grounded theory were undertaken to code data collected from narrative interviews. The major themes that emerged included therapeutic relationship / rapport building, therapeutic techniques, directness / transparency, coordination of care / providing resources, providing psychoeducation, cultural acknowledgment, and clinician's intuition. Limitations, strengths, and recommendations for future directions are discussed.

*Keywords:* strategies, engagement, youth, barriers

## Introduction

Approximately one-fourth of youth experienced a mental disorder during the past year and about one-third during the course of their lifetime (Merikangas, Nakamura, & Kessler, 2009). Nearly 80% of youth with psychological disorders have unmet need, which is defined as children who need mental health services and do not receive them (Kataoka, Zhang, & Wells, 2002). Many youth who need treatment are never referred to mental health services and current studies estimate that only 21% of children who require a mental health evaluation actually receive services (Kataoka et al., 2002). Of the children and families who actually receive mental health treatment, it is estimated that between 30 and 80% terminate prematurely, with many completing less than half of the clinician-recommended course of therapy (Gonzales, Weersing, Warnick, Scahill, & Woolston, 2011; Ingoldsby, 2010; Robbins, Turner, Alexander, & Perez, 2003; Warnick, Gonzales, Weersing, Schail, & Woolston, 2012). These are concerning numbers, given that children and adolescents who drop out of treatment prematurely are found to function more poorly in a variety of settings including school, social situations, and at home, than those who complete an adequate course of therapy (Robbins et al., 2003). Warnick and colleagues (2012) found that families who discontinue services prematurely may require more intensive and more costly services in the future due to continued and even worsening symptoms. Youth who are untreated for mental health problems exhibit a number of problems including academic underachievement, substance dependence, increased likelihood of future conduct problems, delinquency and criminal activity, as well as increased risk of mental health problems in adulthood (Gonzales et al., 2011; Perou et al., 2013).

The literature identifies several barriers that increase the risk for youth prematurely terminating from therapy. Premature termination has many definitions in the literature, but is

often defined as clients dropping out of therapy before the clinician-recommended course of treatment or before treatment goals have been achieved (Gopalan et al., 2010; Oldham, Kellet, Miles, & Sheeran, 2012). Barriers to treatment have previously been categorized into several domains including barriers related to family or environmental characteristics, logistical barriers, and therapeutic or perceptual barriers (Kazdin, Holland, & Crowley, 1997). Family and environmental characteristics that have been recognized as potential treatment barriers include experiences such as poverty or financial issues, including low income and competing financial responsibilities, single parent status, and family distress, including recent crises, psychosocial stressors or stress related to family dynamics (Gopalan et al., 2010; McKay & Bannon, 2004). Logistical barriers have been defined as practical or concrete obstacles (Gopalan et al., 2010), and include barriers such as lack of transportation to services, lack of childcare, insufficient time due to holding multiple jobs or other increased commitments (Garcia & Weisz, 2002; Gopalan, et al., 2010). These factors have been found to be associated with lower or lack of engagement with mental health service providers (Gopalan et al., 2010). Perceptual and therapeutic barriers have been defined as client perceptions about therapy or any experiences or feelings about the therapeutic relationship that may impede treatment (McKay & Bannon, 2004). Perceptual and therapeutic barriers noted in the literature have included inaccurate or incomplete information about the nature of therapy, stigma and other beliefs about mental health, and negative experiences with prior therapy (Lindsey et al., 2013). In addition, therapeutic barriers have also included any experiences that lead to poor therapeutic alliance (Kazdin et al., 1997; McKay & Bannon, 2004), which may include clients experiencing clinicians as intrusive, as well as a lack of attention to or respect for cultural factors, or imbalances in rapport with youth and parents (Gopalan et al., 2010). Other perceptual and therapeutic barriers discussed in the literature

include the level of perceived need for treatment, or how relevant the parent or youth believes treatment to be, as well as expectations for therapy outcomes and treatment demands (Garcia & Weisz, 2002; Gopalan et al., 2010). For instance, expectations about the length of the therapeutic process or expectations about potential outcomes may ultimately contribute to premature dropout in the event that clients have an inaccurate understanding of therapy and potential outcomes (Garcia & Weisz, 2002; Gopalan, et al., 2010).

In summary, the literature suggests that premature termination of youth treatment may contribute to many negative short-term and long-term consequences for youth, their families, and their communities. Further research is needed to identify commonly used strategies for addressing and overcoming these barriers to treatment to evaluate their effectiveness in preventing premature termination and to reduce the occurrence of these negative outcomes.

### **Strategies for Addressing and Overcoming Treatment Barriers in the Literature**

Extant studies have attempted to address issues related to engagement and improving treatment retention, but most studies have focused on strategies for adults in mental health services (e.g., motivational interviewing, case management, psychoeducation and providing appointment reminders; Lindsey et al., 2013; Oldham, Kellet, Miles & Sheeran, 2012). Some progress has been made in family and youth mental health services, but the literature for this population is scant in comparison to the adult literature, and there is still much to learn in order to make meaningful advances in the practical application of interventions designed to address barriers (Bannon & McKay, 2005; Gopalan et al., 2010; Lindsey, et al., 2013). The most commonly identified interventions and strategies identified in the literature when addressing children's mental health engagement include assessment of the client's needs, psychoeducation about therapy, giving homework assignments, providing appointment reminder phone calls or

letters, addressing parent concerns about the therapeutic process, and taking steps to increase accessibility to treatment (e.g., by providing bus tokens, money for gas, or childcare; Gopalan et al., 2010; Lindsey et al., 2013). A recent meta-analysis found that psychoeducation, assessment, (i.e., any means by which the clinician measures the client's strengths and needs), accessibility promotion, (i.e., any strategies used to make services convenient or more accessible), and assigning homework, had a high likelihood of being effective for youth and families (Lindsey et al., 2013). These techniques were most commonly associated with treatment approaches found to be superior to comparison groups on measures of therapy attendance and adherence (Lindsey et al., 2013).

Recent research has highlighted the utilization of technology-based techniques to address logistical barriers, such as text-message appointment reminders and online scheduling systems (Gopalan, et al., 2010; Tambling, Jonson, Templeton, & Melton, 2007). However, research in this area appears to be scarce and the effectiveness of these techniques is not yet established. Other interventions aimed at addressing barriers to treatment include the use of strength-based approaches, defined as methods that build on family members' competencies and enhances families' strengths and relationships rather than focusing on deficits (Gopalan et al., 2010). Strength-based approaches include the use of specific strategies such as augmenting the strengths of families, including recognition of the child's knowledge, competencies, capabilities, and resources, as well as emphasizing cultural strengths, such as pride in one's culture and identity, religious faith or spirituality, talents and artistic appreciation, practical living skills, and reinforcing connection with interpersonal supports and community involvement (Gopalan et al., 2010; Hays, 2009). Motivational Interviewing is another strength-based approach that has been implicated in the improvement of retention rates among adults, but has not yet been evaluated

with regards to retention improvement with youth clients and their families (Gopalan et al., 2010). Additionally, the research supports working to increase access to treatment that takes place outside of conventional mental health clinics (such as in homes or at schools) in order to increase the likelihood of attendance and adherence and decrease logistical barriers (Gopalan et al., 2010; Lindsey et al., 2013).

Overall, the literature samples useful strategies for addressing practical concerns and provides some promising suggestions for interventions that may address the therapeutic and attitudinal barriers to youth and family treatment. Research in this area is complex, due in part to the differing perceptions of clients and therapists with regards to treatment initiation and engagement, treatment outcomes, and treatment termination. For example, some research has shown that therapists' expectations of treatment length are usually longer in duration than clients' expectations of treatment length (Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008). Barrett et al. (2008) suggest that therapists typically accurately identify the clients' reasons for terminating when they are positive, such as gaining symptom relief, but are significantly less likely to correctly identify reasons for termination that are negative, such as dissatisfaction with the therapist. Barrett et al. (2008) further explain that clients often hide their negative feelings about therapy from their therapist, making it harder for the therapist to evaluate the reasons for poor treatment outcomes accurately. This may be even more relevant for youth clients, given the complex interaction of developmental and therapeutic factors. For instance, Oetzel and Scherer (2003) suggest that disclosing information about psychological problems or discomfort may be in direct conflict with adolescents' developmental stage, wherein they are striving for autonomy. Moreover, being subjected to a therapist's probing or intrusive questions may lead youth clients to feel vulnerable, threatened or unsure of themselves which would likely

impede them from sharing negative feelings about treatment with their therapist (Oetzel & Scherer, 2003). If the barriers to treatment for a specific client are not correctly identified, it may also be difficult for the clinicians to utilize the most effective types of strategies to address the barriers that are directly impacting the treatment process. Therefore, it is important to explore these perceptual differences between therapists and clients regarding barriers encountered in treatment, as well as what is currently being utilized to enhance the treatment process. This exploration should help clinicians to design interventions for premature termination that work effectively.

This study attempts to address one part of the existing problem by exploring therapist perceptions of barriers encountered in therapy with youth and families and the strategies that are being utilized by clinicians to reduce these barriers in treatment-as-usual.

### **Hypothesis for Investigation**

In order to gain a clearer understanding of the practices currently being utilized in the field, a qualitative examination was conducted of therapist perceptions regarding what they perceived as the most effective strategies for addressing barriers with their youth and family clients. Mental health providers were selected for examination in this study in order to gain a deeper understanding of the treatment engagement process from the valuable perspective of clinicians. Given their unique position as providers in the treatment process, mental health practitioners may be able to discuss factors that have contributed to premature termination and to delineate strategies that have improved treatment retention for their youth and family clients. The specific aim of this study is to examine the strategies that mental health providers use to address barriers encountered in therapy-as-usual with youth and family clients. Our objective is to

explore common strategies used by mental health providers, therefore, no specific hypotheses regarding types of strategies were formulated.



## Methods

### Research Design

**Qualitative data analysis approach.** Qualitative data analysis procedures were utilized in order to code and draw conclusions from the collected data using the Dedoose software application. Data analysis was approached by utilizing grounded theory concepts which “aims to produce innovative theory that is ‘grounded’ in data collected from participants on the basis of the complexities and of their lived experiences in a social context” (Fassinger, 2005, p. 157). First, the data was prepared for an inductive content analysis. Data was approached to find theory and allows the move towards a hypothesis rather than starting with one.

### Recruitment

After receiving full IRB approval, clinician participants were recruited for the study. The first step in the recruitment process included contacting 21 clinics within Los Angeles county, asking to speak to the clinic director or a licensed staff clinician, and requesting permission to visit the clinic in order to post the recruitment letter and flyer. Once permission was granted by a staff member of the agency, a research associate visited in person to post the flyer. If permission was not granted, no further action was taken. Following distribution of recruitment letters and flyers, interested participants contacted the project as directed by the letter and flyer, either through phone or email. The contact information for the project was a centralized confidential voicemail system and email address accessible by research associates only. Following contact by interested potential participants, research associates returned contact by phone to schedule an in-person individual or small group meeting with individuals to overview the project, complete consent forms, and administer the questionnaire and interview. In this initial phone contact prior to the in-person meeting, research associates overviewed the project, emphasized the voluntary

nature of participating in the study, and ensured that potential participants understood they could withdraw participation at any time. In the in-person meeting, research associates once again overviewed the project, emphasized the voluntary nature of participating in the study and reminded participants that they could withdraw participation at any time. Furthermore, a script was utilized to review the consent form, which once again emphasized the voluntary nature of participating in this study and the option to withdraw participation at any time.

**Compensation and funding.** As an incentive to participate in the study, every individual who attended one of the interview sessions was offered a \$35 Target gift card. Participants were offered the gift card whether or not they chose to complete the survey (e.g., withdrawing participation during a data collection session). Thus, the receipt of the gift card was not contingent on completing the data collection interview.

### **Data Collection and Interviewing**

All data collection occurred through either individual interviews conducted by one research interviewer, or small focus group interviews (3-8 participants) conducted by one or two research interviewers. During the interview, each participant was invited to complete a self-report questionnaire and also to provide narrative answers to verbal questions.

**Demographic questionnaire.** The first part of the data collection strategy involved the distribution of a brief written quantitative questionnaire, which was completed individually by each participant on his or her own (please see Appendix A for the Demographic Questionnaire). Clinician Participants were asked to complete a brief demographic questionnaire which asked them to report their age, gender, race/ethnicity, marital status, relationship of adults in household, household income, primary language, years residing in the U.S., education attainment (i.e., less than high school, high school/GED, some college, 2-year college degree, 4-year college degree,

master's degree, doctoral degree, professional degree), professional status (i.e., practicum student, intern, LCSW, MFT, MSW, Psy.D., Ph.D., other), years of practice as a clinician, and current type of practice setting (i.e., private practice, medical group, community mental health clinic, school/university based counseling center, social services agency, outpatient hospital, residential treatment center, inpatient hospital, other).

**Interviews.** The second part of data collection for this study involved conducting individual and group interviews with counselors, where the trained interviewers followed a standard format of reading aloud open-ended questions from the interview script and participant responses were recorded using a confidential audiotape. Eight interviewers were trained in the interview protocol by the auditor of this study to conduct interviews with clinician participants. The interview protocol consisted of a semi-structured interview script which posed 10 open-ended questions regarding clinician perceptions of barriers to treatment for patients, and strategies they utilize to encourage patient participation and retain patients in services. Specific questions included asking participants how they discuss barriers to treatment with their clients, and how their clients communicate with them about barriers they are experiencing. They were also asked to discuss what strategies seem to be effective in maintaining client attendance, as well as methods they utilize to overcome logistical barriers with clients, such as transportation or financial barriers. In addition, the participants were asked about ways in which they overcome therapeutic barriers with their clients, such as lack of motivation or unrealistic expectations. The participants were also asked to discuss their perceptions of the importance of rapport and methods they use to establish strong therapeutic relationships (please see Appendix B for our interview protocol).

Our data was gathered from 4 individual interviews and 6 group interviews between February and August of 2012. The group interviews involved approximately 3-8 clinician participants and 1-2 researchers/interviewers. The individual interviews were completed in an average of 30 minutes, and the small group format sessions were completed in an average of 45 minutes.

## **Participants**

**Clinician participants.** Clinician participants included 36 counselors from two local mental health clinics including Open Paths Counseling Center and South Bay Center for Counseling. The participants included 10 practicum students (30.3%) working under licensed clinicians, 9 interns (26.5%), 2 licensed clinical social workers (5.9%), 7 marriage and family therapists (20.6%), 1 social worker (2.9%), and 4 psychologists (11.7%). One participant out of 36 did not respond to this item. The participants included 23 females (67.6%), 10 males (29.4%), and 1 (2.9%) who identified as other. Two of 36 participants did not respond to this item. The participants included 17 White participants (50%), 2 African American participants (5.9%), 10 Latino participants (29.4%), and 5 participants from other ethnic backgrounds (14.7%). Two participants did not respond to the ethnicity question. Participant age range spanned from 25 to 62 years of age ( $M=41.09$ ,  $SD=10.33$ ). The participants' educational backgrounds were composed of 67.6% masters degrees, 14.7% 4-year college degrees, 14.7% doctoral degrees, and 2.9% professional degrees, with years in the profession ranging from one to 39 ( $M=8.62$ ,  $SD=9.840$ ). Primary practice settings included community mental health clinic (61.8%), private practice (20.6%), other (5.9%), school or community based counseling center (2.9%), social services agency (2.9%), and 5.9% did not indicate. 94.1% endorsed English as their primary language, although only 79.4% indicated English as the language spoken in the home.

Clinician participants had two different patterns of missing data. Two participants omitted ethnicity and sex responses and one participant omitted professional status response. Complete data was achieved for 33 of the 36 clinician participants (91.7%). The remaining 3 (8.3%) participants had at least one study variable with missing data. Patterns of missingness were analyzed using descriptives, and demographic characteristics of the clinician participants who had complete data were comparable to those with incomplete data. The missing data points occurred as a result of participants accidentally omitting an answer on a questionnaire, and the data appeared to be missing at random (MAR).

**Research team.** The research team was composed of three graduate students, who acted as coders, and one auditor. The background of each researcher was considered in order to address potential biases and desired outcomes of the study.

The first researcher is a 27-year-old, African American female clinical psychology doctoral student. She emerged from a diverse socioeconomic background. She was raised in an upper-middle class environment, and lived equally in a northeastern state and a southeastern state. Although her parents are divorced, she and her sibling always had active parents who instilled Christian values, which translated into her active participation in the African Methodist Episcopal church. Based upon her background that encapsulates a wide variety of experiences, she understands the stigma behind mental health services that leads to treatment barriers, but believes that everyone could benefit from psychotherapy.

The second researcher is a 28-year-old, Caucasian female clinical psychology doctoral student. She was raised in Texas in an upper-middle-class family with one sibling and parents who are still married. Her background includes being raised in a Christian family and being taught that therapy is effective and worthwhile. She does not currently practice any specific

religion, but maintains spiritual beliefs in a higher power. Based upon her background, previous experiences, and psychology training, she believes that everyone could benefit from psychotherapy and that everyone deserves to have adequate treatment for their mental health needs.

The third researcher is a 48-year-old, Arab-American Caucasian female clinical psychology doctoral student. She was born in Beirut, Lebanon and lived in Greece, Dubai and Cypress. She was raised in an upper-middle class family with two siblings and parents who remained married until 2010 when her father became a widow. Her background includes being raised in a Christian family even though her mother was a Druze. She is active in her Catholic faith community. Based upon her background that includes exposure to many cultures and religions, she believes that everyone deserves access to mental health services.

The auditor is a 35-year-old, Chinese-American female assistant professor of psychology and licensed psychologist who is the dissertation chair for this project. She is board certified in Clinical Child and Adolescent Psychology by the American Board of Professional Psychology. She was born in Taipei, Taiwan and immigrated to the U. S. at the age of 8, and has lived in various cities in New York and California. As a child she was raised in a working, lower class family until her adolescent years when her parents' hard work resulted in a financially stable environment and they became part of the upper income class. Her parents have been married for 36 years. She was raised with spiritual beliefs, has pursued Catholicism actively since she was 18 years old, and currently actively participates in her faith community in Los Angeles, CA. She understands the stigma and various barriers in the mental health help seeking pathway and believes that everyone should have access to effective evidence-based care regardless of their socioeconomic status or severity of mental illness.

## **Transcription**

Transcription of the sessions was completed by seven masters-level psychology graduate students who were recruited on a volunteer basis. Two of the transcribers were also the researcher participants in this study (Gimel, the 27-year-old African American female and Lyndsay, the 28-year-old Caucasian female). Prior to working with the data for the study, the transcribers were personally trained by the auditor of this study to transcribe sessions verbatim using a system adapted from University of Washington's Thesis Manual. Each transcriber was instructed to utilize a standardized template that listed the time stamp in the first column and the questions posed by interviews and answers provided by clinician participants in the second column. Each audiotape was first transcribed by the first transcriber, then reviewed and edited by a second transcriber. The Lab Manager then reviewed the transcript against the audiotape to ensure accuracy and provided his sign-off to finalize the transcript. The transcription template and training protocol can be found in the Coding Manual (please see Appendices C and D for the transcription template and training protocol, respectively).

## **Coding**

The coders for this study consisted of three doctoral level psychology graduate students (two of which were the primary researchers for the study). Their research supervisor served as the auditor. Prior to coding the transcripts, the 3 coders and auditor practiced coding until they achieved Kappas of .75 and above on inter-rater reliability tests. The coders were trained to understand the essential concepts, terms, and issues that were relevant to the study. The coders were also each trained on the techniques of the coding method to be used in this study.

## **Human Subjects/Ethical Considerations**

Confidentiality and maintenance of ethical standards for the treatment of research participants was maintained in several ways. First, limits of confidentiality for interviews and for research database inclusion were reviewed with clinician participants. All participants provided informed written consent to participate in the interview (please see Appendix E for the informed consent form). All identifying information was redacted interview documents in order to preserve confidentiality upon transfer to the research database. Client participant demographic questionnaires and associated interview responses were assigned a research number to de-identify them for research purposes (Mertens, 2009). All individuals who handled the transfer of clinical data to the research database completed an Institution Review Board (IRB) certification course (please see Appendix F for the certificate).

In addition to the research data preparation, provisions were made so that those handling the de-identified data did so in a confidential and ethical manner. Prior to accessing research database content, researchers/coders, and transcribers completed an IRB certification course and Health Insurance Portability & Accountability Act of 1996 (HIPAA) course to ensure adherence to ethical standards of participant research and handling confidential health information. Further, steps were taken to maintain confidentiality by making sure that research coders did not personally know the clinician participants prior to the study.

## **Researcher Bias and Quality of Study**

To ensure the quality of the study, each interviewer was personally trained by the auditor of the study utilizing standardized instructions for conducting the interviews. In order to consider potential biases that may have impacted coding procedures, the researchers and the auditor first explored their own expectations and biases by discussing the answers they anticipated the



participants to provide and factors from their own personal and clinical experiences that led to specific expectations. This process allowed the coders to develop awareness regarding their own biases, and to consciously set aside their biases and code the data as objectively as possible (Knox, Hess, Petersen, & Hill, 1997). In order to further address potential researcher biases and expectancies, the researchers engaged in self-reflection throughout the coding and analysis phases of the study. This process, known as reflexivity, further ensured the quality of the study. Reflexivity occurs when the researcher engages in critical self-reflection (Miller & Brewer, 2003). This practice requires the researchers to ask themselves a series of questions and reflect on the impact these answers may have had on the data and the analysis of the data (Miller & Brewer, 2003). Continuing the reflexive process at all stages of the study helped the researchers maintain awareness of ethical issues to consider, as well as broader social constructs that may have had an impact on the findings.

**Reliability.** Coding was conducted on all 10 transcripts. Each transcript was coded by three doctoral-level raters and by the auditor of this study using the Dedoose software application. Dedoose is a user-friendly “full featured web-based service for the input, management, analysis, interpretation, and presentation of qualitative and mixed method research data” (Dedoose version 5.0.11, 2014, “Getting Started,” para. 1). Each coder received extensive training in the coding system and referred to a detailed 72-page user guide. Coding and data integrity procedures were implemented and reflected similar studies. Inter-rater reliability among coders was calculated for seven parent codes and 12 child codes providing a total of 19 strategy codes. Kappas for the codes in the current study ranged from .75 to .89. Following this coding procedure, a fourth coder—the auditor, inspected the data for accuracy and obtained a Kappa of .76. Although excellent inter-rater reliability would be a score that approaches .90,

Lombard, Snyder-Duch, and Bracken (2002) suggest that Kappas .80 or greater are considered acceptable in most situations, and that scores of .70 are often used as acceptable levels for exploratory qualitative research. Therefore, the inter-rater reliability scores for the current study suggest acceptable agreement for the codes.

### **Procedures for Analyzing Data**

Qualitative data analysis procedures were utilized in order to code and draw conclusions from the collected data. Transcripts were coded by the researchers using the Dedoose software application. Dedoose is a user-friendly “full featured web-based service for the input, management, analysis, interpretation, and presentation of qualitative and mixed method research data” (Dedoose version 5.0.11, 2014, “Getting Started,” para. 1).

After data preparation, the coders examined the data for specific themes that emerged from the clinician-participants, in accordance with recommendations for inductive content analysis (Elo & Kyngäs, 2007; Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). In accordance with guidelines for qualitative data analysis, the researchers coded the raw interview data by first coming to a consensus about the units to be coded, then coding all of the text and developing categories, and finally drawing conclusions about the coded data by consolidating the categories into overall themes. This three-part process involved open coding, creating categories, and abstraction (Elo & Kyngäs, 2007).

First, open coding began with the three researchers reading through each transcription as many times as necessary, making notes and writing down thoughts and ideas until each felt she captured the essential headings to describe aspects that answered the research question (Elo & Kyngäs, 2007).

Next, the two primary researchers independently grouped similar codes, generating

category/concept labels for each grouping. Using the research question as a guide, the researchers agreed to code the data by searching for references to treatment barriers and strategies for addressing barriers to treatment, as well as any other relevant data. The researchers then submitted the concept groups to the other researcher and auditor for review and feedback in order to identify idiosyncratic analyses or data that was mislabeled (Hsieh & Shannon, 2005). To help ensure reliability of the researchers' process and findings, the auditor reviewed the categories and codes and examined notes that researchers took during the coding process.

The researcher then submitted the concept groups to the third researcher and auditor for review and feedback in order to identify idiosyncratic analyses or data that was mislabeled (Hsieh & Shannon, 2005). To help ensure reliability of the researchers' process and findings, the auditor reviewed the concept groups and abstracted codes as well as examined the steps and notes that the researchers took during the coding process. The purpose of this step was to make certain that the findings of the researchers have dependability and confirmability (Zhang & Wildemuth, 2009). This process involved reviewing data and notes of each researcher. The auditor then separately coded the transcribed data and noted her own thought processes. The auditor then reviewed the data and noted areas of agreement with the researchers' codes as well as areas for further thought. After a consensus was established among all three researchers and the auditor for organizing and coding the data into concept groups, the researchers and auditor each independently coded all transcripts and identified concepts that occurred throughout the data, and assigned sections of text, such as words or phrases, that represented a concept.

Following coding, the two primary researchers organized these groups hierarchically and identified Parent Themes, or theme titles that described one or several concept groupings (Elo & Kyngäs, 2007). The two primary researchers compared the themes they identified and reached an

agreement on ways to collapse the categories into larger themes. More specifically, the researchers explored the categories that were initially identified, conducted cross-analysis procedures by organizing similar themes into categories, and looked for patterns and relationships between the themes and categories (Zhang & Wildermuth, 2009).

In this process, known as abstraction, the researcher moved back and forth between hierarchical concept levels (codes, concept categories/child codes, and parent themes), making sure all were tied back to the research question (Elo & Kyngäs, 2007). The researchers then submitted the theme hierarchy to the third researcher and auditor for review and feedback in order to identify idiosyncratic analyses or data that was mislabeled (Hseih & Shannon, 2005). The auditor reviewed the abstracted codes, concept sub-categories, and Parent Themes, and offered feedback based on her own experience of coding transcripts, reviewing codes, and thinking about the data hierarchically. Following this review, the primary researcher adjusted codes and themes within the hierarchy to incorporate feedback. Final codes were determined after a second review of the hierarchy by the auditor. The coding was rechecked by each coder for consistency and was also reviewed by the auditor to ensure accuracy. Basic frequencies of coded responses were determined for each theme using the Dedoose software program.

Researchers could not assume that an agreed upon coding system would definitely ensure that the entire body of data was coded consistently (Zhang & Wildemuth, 2009). Therefore the checking process during open coding and abstraction was important for a number of reasons, which included minimizing the impact of coder fatigue on coding, accounting for how pre-existing biases of each of the researchers can influence how they chose coding themes, and establishing inter-coder verification (Zhang & Wildemuth, 2009).

## Results

In the current study, 36 participating clinicians were asked open-ended questions about ways in which they address barriers to treatment with youth clients and their families. All of the interviews resulted in the identification of strategies used to address or overcome barriers to treatment. The major themes to emerge from the interviews were *therapeutic relationship / rapport building* (e.g., references to strong rapport, building trust, creating a safe space), *therapeutic techniques* (e.g., motivational interviewing, positive reinforcement, rating scales, Socratic questioning, or any specific technique used to overcome treatment barriers), *directness / transparency* (e.g., using confrontation, being up front, addressing barriers directly), *coordination of care / providing resources* (e.g., reducing fees, providing bus tokens, providing referrals to adjunctive services), *providing psychoeducation* (e.g., educating clients about the nature of therapy, educating parents of youth clients), *cultural acknowledgment* (e.g., cultural awareness, connecting on cultural similarities, addressing cultural differences that could interfere with treatment), and *clinician's intuition* (e.g., relying on the therapist's instinct). The most commonly identified strategies included references to rapport building, which accounted for 34% of the data, and specific therapeutic techniques, which made up 31% of the data. Strategies that included directness or transparency made up 13% of the data set, and responses that referred to coordinating care or providing resources accounted for 12% of the data. Strategies that involved providing psychoeducation to clients or the parents of clients accounted for 5% of the data set. Statements that referenced cultural considerations made up 3% of the data. Finally, statements that referred to relying on the clinician's intuition in order to address barriers accounted for 2% of the data. Refer to Figure B1 for the distribution of strategies identified by participants.

### **Therapeutic Relationship / Rapport Building**

Building a strong therapeutic relationship was the most commonly identified strategy for addressing and overcoming treatment barriers with youth clients and their families, with 642 out of the total 1,871 codes referencing the importance of rapport or the therapeutic alliance ( $642/1,871 = 34\%$ ). There was general agreement expressed among the participants that the therapeutic relationship is a key element in maintaining engagement and preventing treatment barriers from resulting in premature termination. For instance, one clinician stated, “I think building...that therapeutic relationship is what kind of continues them coming. If you have a strong rapport with them...they kind of feel a connection where they...trust you and they kind of want to continue coming.”<sup>1</sup> Another participant said, “Relationship building is primary...if they don’t trust you, why would they buy into what you’re telling them is going to help them...if that’s not there, everything else...becomes extremely difficult, if not impossible.”

Many participants also discussed ways in which they build rapport, including through validation, empathy and using a nonjudgmental approach. Some of the references to these strategies included statements like, “Empathizing, normalizing, validating...really trying to understand their perspective, what they’re going through, why barriers are barriers,” and “Talk about the things that are interesting to them, that they’re fascinated by. If they’re into video games, understand what they’re playing...[to build rapport].” Similarly, another participant described ways to build rapport including, “being very curious about people and trying to convey as much of that and warmth and sincerity...people can feel that you actually care and you’re not just, uh, you know, just technique.” In all, there was general consensus that building rapport is an

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<sup>1</sup> All quotes were obtained from participants of this study through personal communication with research assistants (April, 2012).

important strategy for overcoming barriers to treatment, with one participant summarizing this sentiment in the concise statement, “Strong rapport. I mean, that’s the main thing.”

### **Therapeutic Techniques**

Another commonly discussed strategy for overcoming and addressing barriers to treatment with youth and their families included using particular therapeutic techniques (586/1,871 = 31%). Responses in this domain included comments from the clinicians that directly referenced the use of specific therapeutic techniques in order to promote engagement, prevent dropout and overcome other related barriers to treatment. For instance, one participant stated, “Technique-wise, you know the things you learn in school, reflective listening, making sure that you understand correctly what they’re saying and...good eye contact...getting a good history at the beginning and really understanding them as holistically as possible.” Another participant stated, “You could even...use some motivational interviewing techniques.” Many of the clinicians referenced the use of open-ended questions and Socratic questioning techniques in order to assess for and address barriers to treatment. For example, one clinician stated, “So when you ask those questions like, ‘What is it that you need?’ or ‘How can I help you?’ I think you...put the ball in their court and you give them a sense of...mastery.” Another clinician referred to a particular time in therapy when this strategy was helpful, stating, “I found that the more, um, I kind of worked with her just with some kind of Socratic questioning, she...really opened up to me when...she kind of got the impression that I’m treating her as the expert, you know.” Some of the other specific therapeutic techniques that were commonly identified included, mirroring, validation, and the use of positive reinforcement. For instance, one clinician described several techniques used for overcoming barriers, including, “a lot of mirroring,

validation, positive reinforcement, um, just kind of sitting with them and letting them feel heard and kind of taken care of emotionally.”

Multiple clinicians also mentioned the importance of goal setting as a strategy for overcoming barriers to treatment. Specifically, one therapist explained, “My standard question is like, okay, if we do our work really well, what’s the outcome? You know, what’s gonna make you glad that you came...and then I write down the goals and we...revisit those,” and another stated, “[A]sking them about their goals and what’s in it for them helps them buy into therapy.” There were several references to the use of parent coaching techniques in order to overcome barriers for working with youth clients and their families. In particular, one therapist explained, “If rapport isn’t established and...opposition remains high, then I’ll suggest to the parent that we do some...parent coaching...and let the child be for a few weeks...versus forc[ing] [the child] into [therapy].” Finally, several clinicians identified the use of particular theoretical orientations and techniques derived from particular theories in order to address or overcome barriers. For instance, one therapist stated, “So I go back to the psychodynamic perspective, [and say], ‘The answer’s inside you. Let’s bring it out, let’s work on that,’” and another participant said, “I would probably have to look at the theory that I’m using and see if I could...change it up to see if we can get them moving again.”

### **Directness / Transparency**

References to using a direct approach and being transparent were frequently identified as strategies for addressing and overcoming treatment barriers (232/1,871 = 13%). In general, there was agreement among many of the clinician participants that utilizing confrontation, directness, and transparency were effective ways to address barriers to treatment, including lack of engagement, difficulty with attendance, or low motivation. Many of the participants described



being up front, and addressing barriers head-on. For instance, one clinician stated, “I talk about it. I’m very up front...I don’t sugar-coat it. I mean, we talk about it right away and fix it.”

Another participant stated, “I’m very up front with it. Because if it’s not working I don’t want to pretend like it is, you know?” Still, another therapist explained, “I try to be as straightforward as possible but...you have to validate before you do that.” Overall, there was a consensus that in order to adequately overcome barriers such as lack of attendance or lack of engagement, it was important to address these issues as they arose, in a direct but empathic manner. For example, one clinician explained, “It takes us confronting those situations...in a firm but compassionate way...so that...they do stick it out and they do see the benefit...” Another clinician explained, “I try to...call that out and put it on the table.”

### **Coordination of Care / Providing Resources**

The importance of providing resources and advocating for clients in order to address barriers made up a significant portion of the interview and focus group discussions (225/1,871 = 12%). References to coordinating care or providing resources included any steps that clinicians or agencies could take to accommodate clients and address logistical or financial barriers. For instance, one participant explained, “I’ll say we can work out a sliding scale and/or depending on how things go, we might be able to reduce frequency, like meet every other week.” Similarly, another therapist stated, “Lack of money, I’ll try to work out a sliding scale.” Frequent references were made to strategies such as reducing fees or offering sliding scales, providing bus tokens for clients, and offering flexible hours or connecting clients with community resources. One clinician stated, “No childcare is something, I’ll have a phone session, or... I’ll be flexible, sometimes come in Saturday mornings and work my schedule around theirs if possible.” Another participant gave an example of working with one particular family stating, “I try to find

resources for them...for example I have a client with five kids that comes here and somehow I was able to set that up with my supervisor to provide childcare so they can come and have...their therapy.” In addition, many participants discussed the importance of providing referrals to adjunctive or alternative services when needed, in order to address barriers. For instance, one clinician stated, “If for some reason, individual therapy is not really accessible to the client for a time or money or whatever reason, we’ll end up either offering them a subservice, or...an alternative service.” Overall, there was widespread agreement that providing resources, referrals, and accommodations, are necessary strategies for overcoming barriers to treatment when working with youth clients and families.

### **Providing Psychoeducation**

Many participants discussed the importance of providing psychoeducation about the nature of therapy in order to address and overcome barriers to treatment (91/1,871 = 5%). For instance, one clinician stated, “I try to give them...a little bit of psychoeducation at the beginning so that they have...an idea of what therapy is, especially therapy in the context of working with a family, which is very different than when you work with an...individual or an adult...” Another clinician explained a particular method of providing psychoeducation stating, “We actually created a flyer that says... ‘What is psychotherapy?’ and it says exactly what it is and that you should talk to your therapist if you’re not feeling...comfortable.” Other statements made by the participants included statements about providing psychoeducation to parents of child clients in order to overcome barriers such as dropout or parent frustration with slow progress. For example, one clinician stated, “Parents...who are...high achievers...expect the same for their kid, so it’s educating them on, look...this is not you... she might be part of you, but she’s got her own little budding personality too and we have to work with that...so it’s educating the parents.” Still other

participants discussed ways to educate clients about the course of therapy in order to overcome barriers to treatment such as premature dropout or lack of engagement. For instance, one therapist described something they might say to a client such as, “[D]epression didn’t happen overnight, so you’re not going to see progress overnight.” In all, the participants tended to agree that psychoeducation was an important strategy for addressing and overcoming barriers for youth clients and their families.

### **Cultural Acknowledgment**

The participants discussed the importance of considering and acknowledging cultural factors in order to overcome potential barriers to treatment (51/1,871 = 3%). Participants discussed awareness of gender, age, ethnicity, religion, and other dimensions of cultural identity that may have an impact on treatment. The discussions included an emphasis on communicating in a respectful manner and understanding the client’s worldview in order to overcome or prevent barriers to treatment. For instance, one therapist explained the importance of cultural awareness in order to prevent barriers that might interfere with treatment stating, “[A]wareness of the culture, who they are, the ethnicity, the age, why they’re there, the sensitivity around the subject matter...to be really careful with what we say.” Another participant stated, “I’ll include issues of culture...and I’ll say, ‘Are you comfortable seeing a male?’...or ‘Do you see any cultural issues that are barriers that...you think would stand in our way?’ and we can talk about that.” Other statements included particular examples of cultural considerations that have come up for the clinicians in their own work, such as, “I’m careful about the language, too...I say counselor, or...[I’ll ask] ‘Have you ever spoken with a counselor or a priest?’” The discussions also included the importance of understanding and addressing cultural similarities and/or differences between the client and therapist in order to prevent or overcome treatment obstacles. For

example, one clinician gave a specific example stating, “My family is from El Salvador so if it’s an El Salvadorian family...I’ll ask where they’re from...and then I’ll...disclose, ‘Oh, my parents are from this city...’” Other statements included the importance of “building the connection, like a cultural connection.” There was general agreement that cultural awareness is an important aspect of establishing a connection and preventing or overcoming treatment barriers.

### **Clinician’s Intuition**

Relying on instinct or the clinician’s intuition was discussed as a strategy for identifying and addressing barriers to treatment (44/1,871 = 2%). References to intuition included statements about the therapist relying on gut instincts when assessing for and addressing barriers to treatment. For instance, one clinician explained, “You see them one foot out the door or you could feel something going on.” Similarly, another participant stated, “In the room, you kind of sense it. It’s like...intuition. Like there’s something wrong. Something doesn’t feel right.” The participants often referred to having a feeling or identifying and addressing potential barriers by attending to their instinctual responses. For example, one therapist explained, “You can tell too, when you first sit down you get that vibe.” Another clinician stated, “It’s just a feeling, like I mean I can tell if I clicked with a person.” In general, the clinician participants noted the role that intuition plays in identifying and addressing treatment barriers with youth clients and their families.

## Discussion

In this study, we sought to identify strategies mental health providers used in order to address treatment barriers for youth clients and their families. Strategies illuminated in this study may help to enhance the literature in this area and lead to a better understanding of the treatment-as-usual approaches to overcoming treatment barriers and increasing treatment engagement for youth clients and families. Since the current study was exploratory in nature, no specific hypotheses were generated.

Results suggested that clinicians believe building a strong therapeutic relationship is one of the most important strategies for overcoming treatment barriers, with 642 out of the 1,871 (34%) codes referring to the importance of building strong rapport. This finding is consistent with previous studies about the importance of the therapeutic working alliance in treatment retention (Garcia & Weisz, 2002; Horvath, 2001; Staudt, 2007). It is important to note that some of the literature uses the term *alliance* interchangeably with the term *engagement*, suggesting a need for more clearly operationalized definitions for these concepts. In general, however, this finding may further underscore the importance of training therapists in foundational methods for building strong rapport with clients in order to increase treatment retention.

Our results also suggested that clinician participants identified the use of specific therapeutic techniques as a useful strategy, with 586 out of the 1,871 (31%) codes referencing specific therapeutic interventions or techniques. This theme encompassed a wide range of many established therapeutic techniques including Socratic questioning, motivational interviewing, general cognitive-behavioral therapy (CBT) techniques, and psychodynamic techniques. This aligns with literature that supports using various therapeutic techniques as engagement strategies with youth, including behavioral contracting, modeling, and homework (techniques that all align

with CBT), as well as motivational interviewing and problem-solving techniques (Lindsey et al., 2013). This finding suggests that the clinician participants have likely utilized many of these techniques in treatment-as-usual and found them to be useful in overcoming barriers to treatment with youth clients and their families.

The participants in the current study made frequent references to using confrontation and directness in order to overcome barriers to treatment, with 232 codes out of the 1,871 codes (13%) identifying the use of directness or confrontation. This is consistent with literature that suggests engaging youth clients in therapy necessitates a more directive approach than working with adult clients (Oetzel & Scherer, 2003). However, there is an important difference identified in the literature between a straightforward approach and a confrontational approach. While there are findings that support the use of confrontation with adult clients in order to overcome treatment resistance or other barriers, research suggests that confrontation may in fact be counterproductive and lead to dropout for some adolescent and youth clients (Oetzel & Scherer, 2003). For instance, Oetzel & Scherer (2003) explain that while it has been found to be useful to directly address stigma associated with therapy when working with adolescent and youth clients, other techniques such as confronting and prompting are often received as intrusive and domineering by adolescent clients, given their developmental stage and search for autonomy. In the current study, it appeared that the clinician participants utilized terms such as “directness” and “confrontation” interchangeably. However, it should be noted that many of the participants made it clear that it was important to always couple confrontation with empathy or gentleness. Thus, it could be illuminating for future research to operationally define and explore differences between directness and confrontation.

The literature suggests that common barriers to treatment include financial and logistical treatment demands that prohibit clients from accessing treatment (Garcia & Weisz, 2002; Kazdin et al., 1997). Clinician participants identified accessibility promotion or the provision of resources as an important strategy. There was a shared belief across clinicians that providing resources and coordinating care may play an important role in overcoming barriers to treatment, with 225 out of the 1,871 codes (12%) referring to resources and coordination of care (e.g., providing bus tokens, adjunctive referrals, childcare). This finding suggests that mental healthcare providers recognize the need for therapists to provide resources and increase accessibility to services, even if their respective agencies do not have the ability to provide some of these resources. This finding has important policy-related implications and suggests more funds should be allocated to provide the aforementioned resources. Future studies should interview youth and family clients to examine the most needed resources from their perspectives.

Psychoeducation about services has been defined in the literature as “provision of information about services or the service delivery system to increase the likelihood that clients will be prepared for services and actively participate in treatment” (Lindsey et al., 2013, p. 289) and includes providing information about session frequency, role of the therapist and other pertinent information. Literature supports psychoeducation as an effective strategy for improving rapport, engaging parents into the treatment process, and providing hope for positive treatment outcomes (Gopalan et al., 2010). In line with existing research, results indicated that clinician participants utilized psychoeducation about services as a strategy (91 out of 1,871 [5%] of codes). This finding suggests that clinicians are aware of the potentially positive impact of providing psychoeducation even if it comprised a smaller percentage of codes overall. It is possible that clinicians identified this as an important strategy, in part because it is included as a

component of most evidence-based treatment protocols that clinician participants may have been exposed to during their work in community mental health agencies. It is also likely that many of the clinician participants have experienced the positive benefits of providing psychoeducation firsthand with their clients and are endorsing its use anecdotally.

Results also suggested that the consideration of cultural factors was important in addressing barriers to treatment, with 51 codes referencing cultural considerations (3%). This theme is consistent with literature that underscores the importance of culturally responsive care and individualizing treatment in a manner that works best for each family based on a clear understanding of their needs and values (Becker, Buckingham, & Brandt, 2015; Hays, 2009). It may follow that when clients feel understood on a deeper level, they will be more likely to engage in treatment and trust their therapist's work. However, it is significant to note that cultural considerations make up a notably small portion of the data in this current study, although researchers have long hypothesized that certain cultural attitudes, values, beliefs, and/or behaviors (such as parental acculturation levels) may act as barriers to mental health service use for these populations and help explain differential use for youth and their families (Cauce et al., 2002; Ho, Yeh, McCabe & Hough, 2007; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). While it is possible that some of the clinician participants were considering cultural competence to be implicitly understood as part of building strong rapport, it is still important to consider alternative explanations for this result. Whaley and Davis (2007) note the inadequate attention, both in clinical practice and in the literature, that is devoted to conceptualizing culture and considering cultural context when delivering mental health treatment and conducting psychological research. Moreover, Miranda and colleagues (2009) indicate the major gaps that currently exist in the literature on providing evidence-based treatment interventions with diverse



populations. Thus, the low frequency with which references to cultural considerations emerged in the current data raises concerns about the attention and awareness being paid to issues of sociocultural context and competency in treatment-as-usual settings. These findings further reflect the need for expanded empirical research and improved training and education on culturally competent service delivery (Whaley & Davis, 2007).

An interesting finding suggested clinician participants rely on their intuition as a useful strategy, a theme that represented 44 out of 1,871 (2%) of codes. While some researchers have argued that intuition is not easily measured and is not empirically based (McMahon & Ward, 1998), emerging research seeks to explain the underpinnings and value of intuition (Marks-Tarlow, 2014). Although research on clinical intuition is in its infancy, there are preliminary studies that suggest intuition taps into implicit learning and memory and draws on perceptions and responses within the context of the present moment (Marks-Tarlow, 2014). Marks-Tarlow (2014) suggests that an intuitive clinical approach guides the clinician's attention to what is most salient and expands the potential for exploring new and uncharted territory with clients. However, other literature warns that intuition is complicated and may lead to bias, distortion, and assumptions by the therapist (Bove & Rizzi, 2009; McMahon & Ward, 1998). Future research may continue to explore the utility of clinician intuition and if found to be helpful, whether a theoretically-based training program can be developed to systematically teach clinicians to use intuition in an evidence-based fashion.

### **Limitations**

The current study has several limitations that should be considered when interpreting the findings. First, although the sample size was relatively large for a qualitative study, it is also important to note that the participants came primarily from two community-based agencies in the

Los Angeles area. Thus, the results may not be meaningfully generalized to all therapists or mental health professionals working in different regions of the country and in other practice settings. When considering the strategies identified in the study, it is important to note that the findings represent the perspective of therapists and do not account for clients' perspectives. Moreover, while the therapists were asked to discuss the strategies that have been most useful in their own work, it is necessary to recognize that the current study was not purporting to identify the most effective strategies, but rather to identify the strategies commonly used by and perceived as useful by clinicians in treatment-as-usual settings. Given this distinct limitation, it would be important for future studies to gather information about the clients' experiences. More specifically, it would be particularly illuminating to gather data about the experiences of youth clients as well as parents of youth clients. In addition, it would be useful for future studies to work to evaluate the effectiveness of the strategies identified in the current study by directly linking the use of specific strategies to specific outcomes such as dropout rate or clients' self-rated engagement in treatment.

### **Strengths**

This study had a number of strengths. Specifically, the large sample size added to the quality of the study, given that qualitative research often consists of small sample sizes, with some existing qualitative studies including as few as two or three participants (Creswell, 2013). Baker, Edwards, and Doidge (2012) recommend samples that include at least 12 participants. Thus, the 36 participants included in the current study are well beyond the minimum recommendations for qualitative research and allow for rich and robust information that may not have been captured with a smaller sample. In addition, the study includes a wide range of clinicians at various stages in their careers, suggesting that the information collected is reflective

of practice across various types of professional licenses and of clinicians with varying degrees of experience and education (e.g., interns, LCSW, MFT, MSW, Psy.D., and Ph.D). Another important strength of the current study includes the focus on clinicians who regularly treat youth and families, for whom unique treatment barriers exist, rather than only focusing on treatment with adult clients. Thus, the findings in the study add important information to the extant literature about mental health for youth, which continues to be an understudied area of research (Lindsey et al., 2013).

### **Conclusion**

It is clear that the mental health needs of youth in the United States are not currently being adequately addressed. Many youth in need of mental health treatment are never referred for services (Kataoka et al., 2002), and many others prematurely terminate before treatment goals have been achieved (Robbins et al., 2003). The literature has identified numerous potential negative consequences for untreated or inadequately treated youth mental health symptoms, including negative academic consequences, impaired social relationships, future risk for substance abuse, criminal activity and ongoing mental health diagnoses in adulthood (Perou et al., 2013; Robbins et al., 2003). In order to prevent or mitigate these consequences, it is imperative to identify effective strategies for overcoming treatment barriers to better engage youth clients and their families in service utilization. This study sheds light on the common approaches being used by providers currently working in the field. These findings can inform future studies that aim to identify the most effective engagement strategies for youth clients and those that aim to improve on existing strategies to increase treatment engagement. In addition, the themes identified in the current study may provide valuable information to clinicians who are

currently practicing and may help them to generate ideas for reducing treatment barriers with their own clients.

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## APPENDIX A

## Review of the Literature

Author(s) and Year	Title	Summary of Pertinent Information
Andrade, A.R., Lambert, E.W. & Bickman, L. (2000)	Dose effect in child psychotherapy: Outcomes associated with negligible treatment	<p>No body of evidence to show that mental health treatment for children &amp; adolescents is effective in current condition</p> <p>Positive correlation between improvement &amp; great lengths of psychoanalysis in study using Child BX Checklist</p>
Armbruster, P., & Fallon, T. (1994)	Clinical, sociodemographic, and systems risk factors for attrition in a children's mental health clinic.	Epidemiological data reporting 2/3 of children in need of mental health services fail to receive them
Ascher, B.H., Farmer, B.J., & Angold, A., (1996)	The Child and Adolescent Services Assessment (CASA): Description and Psychometrics.	Child & Adolescent Services Assessment is a self- and parent-report instrument designed to assess the use of mental health services by children 8-18; collects information on whether a services was ever used and more detailed information on services in the recent past
Banerjee, A. & Chaudhury, S. (2010)	Statistics without tears: Populations and samples.	Non-random samples: volunteers who agree to participate; limitations: larger group harder to identify, internal valid, can provide important cues for further studies based on random samples; generalization may be possible
Baruch, G., Vrouva, I., & Fearon, P. (2009)	A follow-up study of characteristics of young people that dropout and continue psychotherapy: Service implications for a clinic in the community.	<p>Dropping out of psychotherapy among young people is a significant problem</p> <p>Internalizing problems: relationship problems &amp; being older increase the likelihood of dropping out</p>

Author(s) and Year	Title	Summary of Pertinent Information
		Externalizing problems: homelessness and being younger increase the likelihood of dropping out
Centers for Disease Control (2009)	National health and nutrition examination survey.	Survey suggests that approximately half of children with mental disorders do not receive mental health treatment within a given year
Copeland, W.E., Miller-Johnson, S., Keeler, G., Angold, A., & Costello, E.J. (2007).	Childhood psychiatric disorders and young adult crime: A prospective, population-based study.	51.4% of male young adult offenders & 43.6% of female offenders had a child psychiatric history
Creswell, J.W. (2013).	Research design: Qualitative, quantitative, and mixed methods approaches.	The core assumption of this method is that the use of a combination of qualitative and quantitative approaches will provide a more complete understanding of a research question than either approach on its own
Cummings, J.R., Wen, H. & Druss, B.G. (2013).	Improving access to mental health services for youth in the United States.	School-based mental health programs may remedy geographic and financial barriers
Denzin, N.K. (2012).	Triangulation 2.0.	Descriptions/definitions of qualitative statistics
DeRigne, L. (2010).	What are the parent-reported reasons for unmet mental health needs in children.	Findings regarding uninsured children  Definition of unmet needs
Flicker, S. M., Turner, C. W., Waldron, H. B., Brody, J. L., & Ozechowski, T. J.	Ethnic background, therapeutic alliance, and treatment retention in functional family therapy with adolescents who abuse substances.	Latino families who did not complete therapy demonstrated more imbalanced alliances during the first session than

Author(s) and Year	Title	Summary of Pertinent Information
(2008).		families that completed therapy
Garcia, J. A., & Weisz, J. R. (2002).	When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment.	Child and adolescent treatment ends for a variety of reasons, little is known about the underlying factors or about whether any such factors are linked to premature dropout.
Gonzalez, A., Weersing, V. R., Warnick, E. M., Scahill, L. D., & Woolston, J. L. (2011)	Predictors of treatment attrition among an outpatient clinic sample of youths with clinically significant anxiety.	<p>Approximately 35-75% of children terminate services before the provider would agree that it is appropriate</p> <p>The relatively small body of work on attrition from youth psychotherapy has yielded inconsistent findings and has been dominated by studies of children and adolescents with disruptive behavior disorders</p> <p>Untreated, early-onset anxiety often continues into adulthood (Dadds et al. 1999; Keller et al. 1992), and predicts academic underachievement, substance dependence (Woodward and Fergusson 2001), and the development of depression and conduct disorder</p>

Author(s) and Year	Title	Summary of Pertinent Information
Gopalan, G., Goldstein, L., Klingenstein, K., Sicher, C., Blake, C., & McKay, M. M. (2010).	Engaging families into child mental health treatment: Updates and special considerations.	<p>Not surprisingly, rates of child psychopathology in low-income inner-city settings have been found to be as high as 40%</p> <p>Close to 1/3 of children and their families fail to engage at the initial face-to-face intake appointment.</p> <p>It is not uncommon for length of treatment to average 3–4 sessions in urban, low-income communities</p> <p>40% to 60% of children receiving outpatient mental health services attend few sessions and drop out quickly</p> <p>Found that at the end of 12 weeks, only 9% of children remained in treatment in urban inner-city clinics</p>
Ingoldsby, E.M. (2010).	Review of interventions to improve family engagement and retention in parents and child mental health programs.	Anywhere from 20 to 80% of families drop out prematurely, with many receiving less than half of the prescribed intervention
Kataoka, S.H., Zhang, L., & Wells, K.B. (2002).	Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status.	In a 12-month period, 2-3% of children 3-5 years old and 6-9% of children and adolescents 6-17 years old used mental health services. Of children and adolescents 6-17 years old who were defined as needing mental health services, nearly 80% did not receive mental health care. Controlling for other factors, the authors determined that the rate

Author(s) and Year	Title	Summary of Pertinent Information
		of unmet need was greater among Latino than white children and among uninsured than publicly insured children.
Kazdin, A. E., & Weisz, J. R. (2003).	Evidence-based psychotherapies for children and adolescents.	Decades of clinical research have generated a growing body of evidence-based treatments for child and adolescent behavioral and emotional difficulties
Kazdin, A. E., Holland, L., & Crowley, M. (1997).	Family experience of barriers to treatment and premature termination from child therapy.	Proposed a barriers to treatment model that included four primary domains that addressed areas shown to contribute to premature termination: 1) the experience of stressors and obstacles, 2) a poor relationship with the therapist, 3) perceptions that treatment is not relevant, and 4) perceptions that treatment is too demanding.
Knox, S., Hess, S.A., Petersen, D.A., & Hill, C.E. (1997).	A qualitative analysis of client perceptions on therapist self-disclosure in long-term therapy.	Before coding the data, researchers should explore their own expectations and biases and code the data as objectively as possible.



Author(s) and Year	Title	Summary of Pertinent Information
Lindsey, M., Brandt, N., Becker, K., Lee, B., Barth, R., Daleiden, E. & Chorpita, B. (2013).	Identifying the common elements of treatment engagements interventions in children's mental health services.	Engagement interventions were most frequently delivered in the clinic setting (62.9 %), followed by the client's home (44.9 %), and other settings (e.g., schools; 7.9 %)
McKay, M.M. & Bannon, W.M. (2004)	Engaging families in child mental health services	<p>Studies have identified several concrete obstacles (e.g., insufficient time, lack of transportation), contextual obstacles (e.g., community violence), and agency obstacles (e.g., time spent on a waiting list) experienced by the family that interfere with use of services.</p> <p>Recent findings support the influence of perceptual barriers as being significantly more salient to understanding engagement in services than logistical barriers</p>
McKay, M.M., Lynn, C.J., & Bannon, W.M.(2005).	Understanding inner city child mental health need and trauma exposure: Implications for preparing urban service providers.	<p>An ecological perspective of mental health need guides the presentation of issues and stressors that occur at the level of the individual child; within the family, school, and community; and within the larger service system context.</p> <p>Results reveal low rates of ongoing service involvement despite multiple, complex presenting mental health issues and significant levels of trauma exposure.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Merikangas, K., He, J., Burstein, M., Swanson, S., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010)	Lifetime prevalence of mental disorders in U.S. adolescents: Results from the national comorbidity survey replication-adolescent supplement (NCS-A).	<p>Total rates of specific disorders were 8.6% for ADHD</p> <p>2.1% for conduct disorder, 0.7% for anxiety disorders</p> <p>0.1% for eating disorders (0.1% for anorexia and 0.1% for bulimia), and 3.7% for mood disorders</p>
Merikangas, K.R., He, J., Brody, D., Fisher, P.W., Bourdon, K., & Korte, D.S. (2010)	Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES.	<p>The overall prevalence of disorders with severe impairment and/or distress was 22.2%</p> <p>Nearly one in three adolescents (31.9%) met criteria for an anxiety disorder, with rates for individual disorders ranging from 2.2% for GAD to 19.3% for specific phobia. Severe anxiety disorders were present in 8.3%</p> <p>The prevalence of ADHD was 8.7%</p> <p>ODD was present in 12.6%</p> <p>6.8% met criteria for CD</p> <p>Substance use disorders were present in 11.4%</p>
Miller, R.L. & Brewer, J. (Eds). (2003).	The A-Z of social research: A dictionary of key social science research concepts.	Reflexivity occurs when the researcher engages in critical self-reflection. This process requires the researchers to ask themselves a series of questions and reflect on the impact these answers may have had on the data and the analysis of the data.

Author(s) and Year	Title	Summary of Pertinent Information
Miller, L. M., Southam-Gerow, M. A., & Allin, R. B., Jr. (2008).	Who stays in treatment? Child and family predictors of youth client retention in a public mental health agency.	The lion's share of research on attrition with child and adolescent research-clinic based samples has occurred in randomized clinical trial (RCT studies) and most of this has focused on youth with externalizing behavior problems, though a few studies of children with internalizing disorders have been conducted. Even fewer studies have occurred in non-research clinical service settings like community mental health centers or private practice settings where treatment endpoints are rarely predetermined
New Freedom Commission on Mental Health (2003).	Achieving the promise: Transforming mental health care in America.	Children with serious emotional disturbances have the highest rates of school failure.

Author(s) and Year	Title	Summary of Pertinent Information
<p>O'Connell, M.E., Boat, T., &amp; Warner, K.E. (Eds.). National Research Council and Institute of Medicine. (2009).</p>	<p>Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.</p>	<p>Associations have been demonstrated between MEB disorders and a number of chronic diseases. For example, one study showed that 16 percent of asthmatic youth ages 11-17 demonstrated criteria for anxiety and depressive disorders. Health professionals in both sectors contribute to the maintenance of good physical and good mental health.</p> <p>The health status of young people has a significant influence on the trajectory of health into adulthood</p>
<p>Onwuegbuzie, A. J., &amp; Leech, N. L. (2006).</p>	<p>Linking research questions to mixed methods data analysis procedures.</p>	<p>Conducting mixed methods research involves collecting, analyzing, and interpreting quantitative and qualitative data in a single study or in a series of studies that investigate the same underlying phenomenon.</p> <p>“its logic of inquiry includes the use of induction (or discovery of patterns), deduction (testing of theories and hypotheses), and abduction (uncovering and relying on the best of a set of explanations for understanding one's results)</p> <p>Providing a bridge between the</p>

Author(s) and Year	Title	Summary of Pertinent Information
		<p>qualitative and quantitative paradigms, an increasing number of researchers are utilizing mixed methods research to undertake their studies.</p>
<p>Perou, R., Bitsko, R.H., Blumberg, S.J., Pastor, R.M., Ghandour, R.M., Gfroerer, J.C., ... Huang, L.N., Centers for Disease Control and Prevention (CDC) (2013).</p>	<p>Mental health surveillance among children —United States, 2005-2011.</p>	<p>A total of 13%–20% of children living in the United States experience a mental disorder in a given year</p> <p>Rate of hospital stays among children for mood disorders increased 80% during 1997–2010, from 10 to 17 stays per 10,000 population</p> <p>Mental disorders might result in serious difficulties at home, with peer relationships, and in school (17–19). These disorders also can be associated with substance use, criminal behavior, and other risk-taking behaviors</p>

Author(s) and Year	Title	Summary of Pertinent Information
Podell, J.L., Gosch, E.A., Albano, A., Rynn, M.A., Sherrill, J.T., Birmaher, B.,...Piacentini, J.C. (2013).	Therapist factors and outcomes in CBT for anxiety in youth.	Research indicates that most anxiety disorders do not abate with time, and if left untreated, youth are at a greater risk for anxiety disorders in adulthood future depression and potential substance abuse.
Robbins, M. S., Turner, C. W., Alexander, J. F., & Perez, G. A. (2003)	Alliance and dropout in family therapy for adolescents with behavior problems: Individual and systemic effects.	<p>Results demonstrated that individual parent and adolescent alliances did not predict retention. However, as hypothesized, dropout cases had significantly higher unbalanced alliances</p> <p>These findings highlight the importance of alliances in functional family therapy and suggest that how the alliance operates in conjoint family therapy may be a function of systemic rather than of individual processes.</p>
Russell, L. (2010).	Mental health care services in primary care: Tackling the issues in the context of health care reform.	<p>Mental health workforce shortages and maldistribution problems</p> <p>The ability of the primary care workforce to diagnose and treat mental health disorders</p> <p>Insurance and financial barriers for patients seeking treatment for mental health disorders</p> <p>Patients' perceptions and fears that are barriers to accessing effective and appropriate treatments for mental health disorders</p>

Author(s) and Year	Title	Summary of Pertinent Information
		Racial and ethnic disparities in mental health services
Tambling, R.B., Johnson, L.N., Templeton, G.B., & Melton, M.S. (2007).	Using web-based technology to facilitate client engagement.	Results indicated that the use of a web-based scheduling system significantly reduced the number of days clients waited for a first appointment and increased the number of kept appointments.
Tashakkori, A., & Creswell, J. W. (2007)	Editorial: Exploring the Nature of Research Questions in Mixed Methods Research.	<p>A strong mixed methods study starts with a strong mixed methods research question or objective.</p> <p>When a project explores mixed research questions with interconnected qualitative and quantitative components or aspects (e.g., questions including “what and how” or “what and why”), the end product of the study (conclusions and inferences) will also include both approaches</p>
U.S. Department of Health and Human Services, (1999).	Mental health: A report of the surgeon general.	21% of U.S. children ages 9 to 17 had a diagnosable mental or addictive disorder associated with at least minimum impairment

Author(s) and Year	Title	Summary of Pertinent Information
U.S. Department of Health and Human Services, (2001).	U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda.	In the United States, one in ten children and adolescents suffer from mental illness severe enough to cause some level of impairment. Yet, in any given year, it is estimated that about one in five children receive mental health services. Unmet need for services remains as high now as it was 20 years ago.
Warnick, E. M., Gonzalez, A., Weersing, V. R., Scahill, L. D., & Woolston, J. L. (2012).	Defining dropout from youth psychotherapy: How definitions shape the prevalence and predictors of attrition.	<p>In line with previous findings, our a priori hypotheses stated that ethnic minorities, single caregiver families, families with state-funded insurance coverage for low-income families, and families where the identified child was referred for externalizing behaviors would be at higher risk of dropping out.</p> <p>Based on two of the definitions evaluated, clinician- rated dropout and missed last appointment, attrition rates in this sample (63.1% and 56.6%, respectively) were similar to rates reported in other outpatient settings</p>
Zhang, Y., & Wildemuth, B. M. (2009)	Qualitative analysis in content	<p>Defining the coding unit is one of your most fundamental and important decisions</p> <p>Qualitative content analysis usually uses individual themes as the unit for analysis, rather than the physical linguistic units</p>



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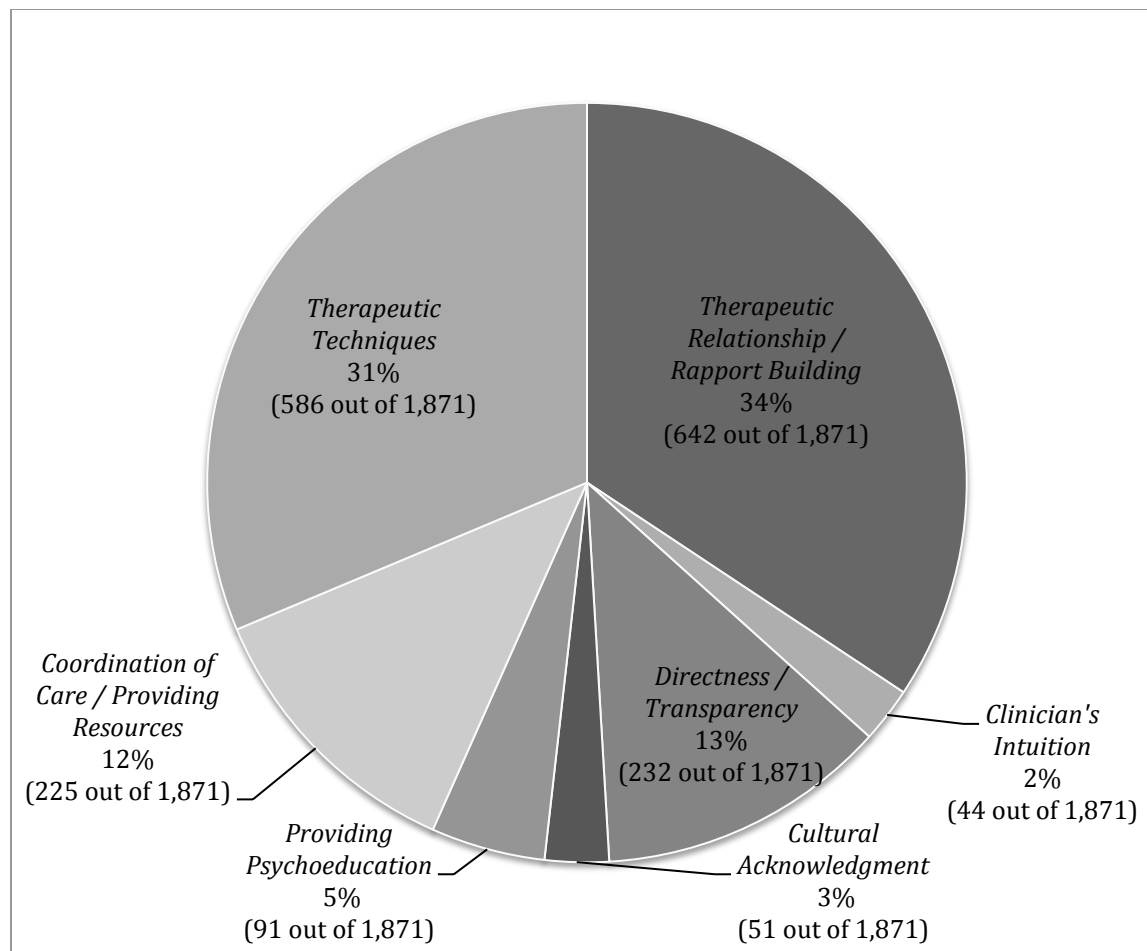
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APPENDIX B

Strategy Code Distribution Chart





*Figure B1.* Strategy code distribution chart. Chart providing the number of codes identified within each theme. Numbers are provided to indicate how many codes were identified for each theme out of the total 1,871 codes. Percentages are also included to denote the percentage of the total data accounted for by each theme.

APPENDIX C

Demographic Questionnaire



**P.A.R.T.Y.**

## DEMOGRAPHIC QUESTIONNAIRE

We would like to start by asking for some background information about you and your family. Your answers will be kept confidential so please try to be as truthful as possible.

### 1. BACKGROUND

- 1a. Age \_\_\_\_\_  
 1b. Sex: M F None/Prefer Not To Say

### 2. FAMILY MEMBERS AND MARITAL STATUS

- 2a. What is your marital status?  
 c Single, never married c Married  
 c Separated c Widowed  
 c Divorced c Living together  
 c In a relationship but living apart

2b. How many children live in your household? \_\_\_\_\_

2c. How many adults (including you)? \_\_\_\_\_

### 3. INCOME

3a. Which category best describes your total household yearly income?

- |                       |                       |
|-----------------------|-----------------------|
| c Less than \$10,000  | c \$10,000 - \$19,999 |
| c \$20,000 - \$29,999 | c \$30,000 - \$39,999 |
| c \$40,000 - \$49,999 | c \$50,000 - \$59,999 |
| c \$60,000 - \$69,999 | c \$70,000 - \$79,999 |
| c More than \$80,000  |                       |

### 4. DEMOGRAPHICS

- 4a. Ethnicity:  
 c White, non-Hispanic c African-American  
 c Hispanic c Asian-Pacific Islander  
 c Native American c Other (please specify) \_\_\_\_\_

4b. Language Preference: \_\_\_\_\_

4c. Language Spoken at Home: \_\_\_\_\_

4d. Years you have resided in the United States: \_\_\_\_\_

4e. Education

**THANK YOU VERY MUCH FOR YOUR COOPERATION, WE GREATLY APPRECIATE YOUR TIME.**

Highest level of education completed:

- c Less than High School
- c High School/GED
- c Some College
- c 2 - Year College Degree (Associates Degree)
- c 4 - Year College Degree (BA,BS)
- c Master's Degree
- c Doctoral Degree
- c Professional Degree (MD,JD)

4f. Please indicate your current professional status or the type of professional credential or license you currently hold.

- c Practicum Student (practicing under licensed clinician)
- c Intern (practicing under licensed clinician)
- c LCSW
- c MFT
- c MSW
- c MD
- c PsyD
- c PhD
- c Other: Please describe \_\_\_\_\_

4g. How many years have you been working in counseling/mental health (including training)?

\_\_\_\_\_

4h. What type of practice setting do you currently work in?

- c Private Practice
- c Medical Group
- c Community Mental Health Clinic
- c School or University Based Counseling Center
- c Social Services Agency
- c Outpatient Hospital
- c Residential Treatment Center
- c Inpatient Hospital
- c Other: Please describe \_\_\_\_\_

**THANK YOU VERY MUCH FOR YOUR COOPERATION, WE GREATLY  
APPRECIATE YOUR TIME.**

APPENDIX D

Interview / Focus Group Protocol



**P.A.R.T.Y.**

### **Interview/Focus Group Protocol**

**For the questions below, please continue to think about the experiences you have had counseling youth and/or family therapy clients. We will record your verbal responses using a digital recorder, so we can make sure that we get all the information you are telling us as accurately as possible.**

**(Research Associate: Please start recorder when participant is ready)**

1. Do you choose to discuss potential barriers to treatment with clients in the initial session or when obstacles arise? How do you discuss barriers with your clients? Please explain.
2. What strategies seem to be effective in maintaining client attendance despite barriers? Please explain.
3. How do you overcome logistical barriers with clients, including but not limited to: lack of money, lack of time, no transportation, no childcare, etc?
4. How do you overcome therapeutic barriers with clients, including but not limited to: lack of motivation, unrealistic expectations, unrealistic goals, slow/no improvement, etc?
5. In your experience, do your clients verbally communicate the stress of treatment obstacles? How do they communicate them?
6. In your experience, do your clients verbally communicate the desire to prematurely terminate treatment? How do they do so?

7. What questions do you believe are important to ask clients at the start of therapy to determine how you can best engage and motivate them throughout the treatment process?
8. How do you adequately gauge clients' satisfaction with treatment?
9. How important is rapport with clients to overcoming potential barriers to therapy?
10. Discuss some ways in which you build rapport with clients.

**Thank you for participating!**

## APPENDIX E

## Transcription Template



Name of Audio Clip:  
Transcriber #1:  
Transcriber #2:  
Final Sign-Off by Lab Manager

0:00	Q: A1: A2:
0:10	
0:20	
0:30	
0:40	
0:50	
1:00	
1:30	
2:00	
2:30	
3:00	
3:30	
4:00	
4:30	
5:00	
5:30	
6:00	
6:30	
7:00	
7:30	
8:00	

APPENDIX F  
Training Protocol

## Qualitative Data Preparation and Transcription Protocol

### TEXT FORMATTING

#### General Instructions

The **transcriber** shall transcribe all individual and focus group interviews using the following formatting:

1. Arial 10-point face-font
2. One-inch top, bottom, right, and left margins
3. All text shall begin at the left-hand margin (no indents)
4. Entire document shall be left justified

#### Labeling Focus Group Transcripts

Individual interview transcript shall include the following labeling information at the top of the document:

*Example:*

Focus Group Location:

Cadre:

Date:

Number of Attendees (if known):

Name of Transcriber:

Number of Tapes:

#### Audiotape Changes

The transcriber shall indicate when the interview is recorded on a new tape and include information verifying that the second side of the audiotape is blank as well as the total number of audiotapes associated with the focus group. This information shall be typed in uppercase letters.

*Example:*

END OF TAPE 1 (3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 1 IS BLANK

START OF TAPE 2 (3 TAPES TOTAL)

END OF TAPE 2 (3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 2 IS BLANK

#### Documenting Comments

Comments or questions by the Interviewer or Facilitator should be labeled with by typing **I:** at the left margin and then indenting the question or comment.

Any comments or responses from participants should be labeled with **P:** at the left margin with the response indented. A response or comment from a different participant should be separated by a return and than a new **P:** at the left margin.

*Example*

**I:** OK, before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand that your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at anytime.

**P:** Yes, I had read it and understand this.

**P:** I also understand it, thank you.

**I:** Do you have questions before we proceed?

#### End of Interview

In addition, the transcriber shall indicate when the interview session has reached completion by typing

END OF INTERVIEW in uppercase letters on the last line of the transcript along with information regarding the total number of audiotapes associate with the interview and verification that the second side of the tape is blank. A double space should precede this information.

*Example:*

I: Is there anything else that you would like to add?

P: Nope, I think that about covers it.

I: Well, thanks for taking the time to talk with me today. I really appreciate it.

END OF INTERVIEW—(3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 2 IS BLANK

### **CONTENT**

Audiotapes shall be transcribed verbatim (i.e., recorded word for word, exactly as said), including any nonverbal or background sounds (e.g., laughter, sighs, coughs, claps, snaps fingers, pen clicking, and car horn).

- Nonverbal sounds shall be typed in parentheses, for example, (short sharp laugh), (group laughter), (police siren in background).
- If interviewers or interviewees mispronounce words, these words shall be transcribed as the individual said them. The transcript shall not be "cleaned up" by removing foul language, slang, grammatical errors, or misuse of words or concepts.
- If an incorrect or unexpected pronunciation results in difficulties with comprehension of the text, the correct word shall be typed in square brackets. A forward slash shall be placed immediately behind the open square bracket and another in front of the closed square bracket.

*Example:*

P: I thought that was pretty pacific [/specific/], but they disagreed.

Filler words such as *hm, huh, mm, mhm, uh huh, um, mkay, yeah, yuhuh, nah huh, ugh, whoa, uh oh, ah,* and *ahah* shall be transcribed.

### **Inaudible Information**

The transcriber shall identify portions of the audiotape that are inaudible or difficult to decipher. If a relatively small segment of the tape (a word or short sentence) is partially unintelligible, the transcriber shall type the phrase "inaudible segment." This information shall appear in square brackets.

*Example:*

The process of identifying missing words in an audiotaped interview of poor quality is [inaudible segment].

If a lengthy segment of the tape is inaudible, unintelligible, or is "dead air" where no one is speaking, the transcriber shall record this information in square brackets. In addition, the transcriber shall provide a time estimate for information that could not be transcribed.

*Example:*

[Inaudible: 2 minutes of interview missing]

### **Overlapping Speech**

If individuals are speaking at the same time (i.e., overlapping speech) and it is not possible to distinguish what each person is saying, the transcriber shall place the phrase "cross talk" in square brackets immediately after the last identifiable speaker's text and pick up with the next audible speaker.

*Example:*

**P:** Turn taking may not always occur. People may simultaneously contribute to the conversation; hence, making it difficult to differentiate between one person's statement [cross talk]. This results in loss of some information.

**Pauses**

If an individual pauses briefly between statements or trails off at the end of a statement, the transcriber shall use three ellipses. A brief pause is defined as a two- to five second break in speech.

*Example:*

**P:** Sometimes, a participant briefly loses . . . a train of thought or . . . pauses after making a poignant remark. Other times, they end their statements with a clause such as but then . . .

If a substantial speech delay occurs at either beginning or the continuing a statement occurs (more than two or three seconds), the transcriber shall use "long pause" in parentheses.

*Example:*

**P:** Sometimes the individual may require additional time to construct a response. (Long pause) other times, he or she is waiting for additional instructions or probes.

**Questionable Text**

If the transcriber is unsure of the accuracy of a statement made by a speaker, this statement shall be placed inside parentheses and a question mark is placed in front of the open parenthesis and behind the close parenthesis.

*Example:*

**P:** I wanted to switch to ?(Kibuli Hospital)? if they have a job available for me because I think the conditions would be better.

**Sensitive Information**

If an individual uses his or her own name during the discussion, the transcriber shall replace this information with the appropriate interviewee identification label/naming convention.

*Example:*

**P:** My supervisor said to me, "P1, think about things before you open your mouth."

**P:** I agree with P1; I hear the same thing from mine all the time.

If an individual provides others' names, locations, organizations, and so on, the transcriber shall enter an equal sign immediately before and after the named information. Analysts will use this labeling information to easily identify sensitive information that may require substitution.

*Example:*

**P:** My colleague =John Doe = was very unhappy in his job so he started talking to the hospital administrator at = Kagadi Hospital = about a different job.

**REVIEWING FOR ACCURACY**

The transcriber/proofreader shall check (proofread) all transcriptions against the audiotape and revise the transcript file accordingly. The transcriber/proofreader shall adopt a three-pass-per-tape policy whereby each tape is listened to three times against the transcript before it is submitted. All transcripts shall be audited for accuracy by the interviewer who conducted the interview or by the study data manager.

**SAVING TRANSCRIPTS**

The transcriber shall save each transcript as a text file rich text file with an .rtf extension.  
For focus groups, the title should include the location of the focus group and the cadre.

## APPENDIX G

### Informed Consent for Clinician Participation



**P.A.R.T.Y. Survey Project**  
**Promoting Attendance and Retention in Treatment for Youth**

**INFORMED CONSENT FOR CLINICIAN PARTICIPATION IN RESEARCH ACTIVITIES**  
**(INTEVIEW/FOCUS GROUPS)**

Participant (Print Name):

Principal Investigator: Judy Ho, Ph.D., ABPP, Assistant Professor of Psychology, Pepperdine University

Title of Project: **Promoting Attendance and Retention in Therapy for Youth (PARTY)**

1) I, \_\_\_\_\_, agree to participate in the research study under the direction of Dr. Judy Ho. I understand that while the study will be under the supervision of Dr. Judy Ho, other personnel who work with her may be designated to assist or act in her behalf. I understand that my participation in this study is strictly voluntary, and that I may withdraw my participation at any time.

2) **PURPOSE OF STUDY:** The objective of this research study is to examine the types of emotional, cultural, therapeutic, and logistical barriers that youth and families experience in mental health treatment and counseling. Furthermore, the study investigates strategies utilized by clinicians, clients, and agencies to overcome emotional, cultural, therapeutic, and logistical barriers to improve treatment retention and reduce treatment dropout. Clinicians/counselors will be asked to report barriers to treatment that have been and are most pervasive in their treatment and referral experiences as well as strategies most effective in increasing attendance, retention, and engagement in therapy.

3) **MY TASKS FOR THIS STUDY:** I will be asked to complete a questionnaire that will provide information regarding my clinical experience. I will also be asked open-ended questions to consider clinical strategies and problems confronted in my clinical experience, and my answers will be recorded via audiotape by the research associate to ensure accurate transcription. However, no identifying information will be recorded on this audiotape, and only research associates will have access to these tapes. I will not be asked to provide identifying or specific information about clients. The interview or focus group will require approximately 30-45 minutes total to complete. This study will be conducted at a location and time convenient to me. I can elect to participate in this study via an individual interview (one-on-one with the research associate) or to participate within a small focus group format (with a few other clinicians and 2-3 research associates). The format of the participation will be up to me.

4) **POTENTIAL BENEFITS OF THIS STUDY:** I understand that there are no direct benefits to me for participating in this study. I understand that my participation may benefit society and the field of



psychological research by increasing understanding and knowledge of potential barriers to mental health treatment and strategies for overcoming these barriers. The data collected may be used to help attain funding to continue this type of research at no cost to mental health clinics, and/or used in research manuscripts or textbooks to help increase public awareness of the barriers to motivation and engagement in youth and family therapy.

5) **POTENTIAL RISKS OF THIS STUDY:** There are no anticipated significant risks for my participation, but some minimal risks include boredom and fatigue while completing the aforementioned questionnaires. If I become bored or fatigued, I understand that I can take breaks at any time. Also possible are some uneasy feelings that may arise when asked to answer questions about my clinical work. If I experience such unease, I may speak with the researcher immediately, or I can contact the principal investigator by phone at (310) 568-5604 following the session. I understand that I may discontinue the study at any time.

6) **CONFIDENTIALITY:** I understand that the principal investigator and her research associates will take all reasonable measures to protect the confidentiality of my records, and my identity will not be revealed in any publication that may result from this project. Only the principal investigator and her research associates will have access to my data, and the data is not linked to any identifying information. Recorded audio will be uploaded onto a secure server, and the audio file will be password protected, and only research associates will have access to the password and the data, stored on official research lab laptop computers in a secured facility at Pepperdine University Graduate School of Psychology, West Los Angeles campus. The hard copy data (written material and audio recordings) may be kept in these locked facilities for 5 years, and will be destroyed when it is no longer required for research purposes. In addition, the information collected will be entered into a computer data analysis program for research purposes. The computer data will be completely de-identified. The findings of this study may be published in research manuscripts, textbooks, or presented at professional conferences. However, data from this study will only be reported in the aggregate, which ensures my anonymity.

The confidentiality of my records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. In the above cases, the researchers are mandated by law to report these issues to the proper authorities, including but not limited to the police department, child protective services, or elder protective services.

If I decide to participate within a small focus group format, all of the above confidentiality considerations apply. In addition, participating clinicians, including myself, will sign an additional form stating that we will keep the information revealed within the focus group confidential.

7) **COMPENSATION:** As incentive for my participation in this project, I will be compensated a \$35 Target gift card. Furthermore, I will receive compensation even if I decide not to participate once I hear more about the study or if I decide not to answer all the questions or complete the survey in its entirety.

8) **QUESTIONS AND CONCERNS:** I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact Judy

Ho, Ph.D. at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045 and/or (310) 568-5604 if I have other questions or concerns about this research. If I have questions about my rights as a research participant, I understand that I can contact Jean Kang, Manager of the Graduate and Professional Schools Institutional Review Board, Pepperdine University at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045 and/or (310) 568-5753.

9) UNDERSTANDING OF THIS CONSENT DOCUMENT: I understand to my satisfaction the information regarding participation in the research project. All my questions have been answered to my satisfaction. I have received a copy of this informed consent form, which I have read and understand. I hereby consent to participate in the research described above.

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

I have explained and defined in detail the research procedure in which the subject has consented to participate. Having explained this and answered any questions, I am cosigning this form and accepting this person's consent.

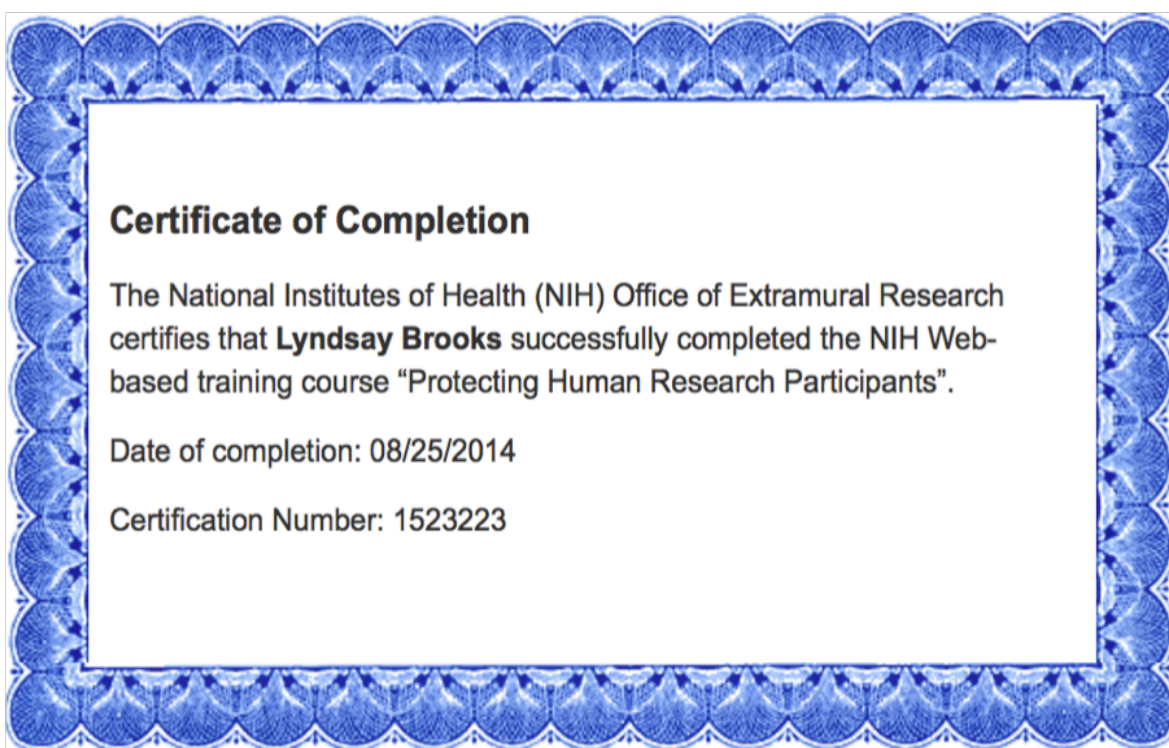
\_\_\_\_\_  
Researcher's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

APPENDIX H

IRB Certification for Protecting Human Research Participants



APPENDIX I

IRB Approval Notice

# PEPPERDINE UNIVERSITY

## Graduate & Professional Schools Institutional Review Board

November 19, 2014

Gimel Rogers  


Lindsay Brooks  


Protocol #: P0914D01/ P0914D02

Project Title: Examining therapists' perceptions of barriers to treatment with youth and their families: A mixed methods study

Dear Ms. Rogers & Ms. Brooks:

Thank you for submitting your application, *Examining therapists' perceptions of barriers to treatment with youth and their families: A mixed methods study*, for expedited review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your advisor, Dr. Ho, completed on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 (Research Category 7) of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

I am pleased to inform you that your application for your study was granted **Full Approval**.

Additionally, you have also been granted approval to access, manage, and analyze the archival data from: **Protocol P0311F19**, *Project Title: Promoting Attendance and Retention in Therapy for Youth*. The IRB approval begins today, **November 19, 2014**, and terminates on **November 19, 2015**.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. One copy of the consent form is enclosed with this letter and one copy will be retained for our records. **You can only use copies of the consent that have been stamped with the GPS IRB expiration date to obtain consent from your participants.**

Please note that your research must be conducted according to the proposal that was submitted to the GPS IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For **any** proposed changes in your research protocol, please submit a Request for Modification form to the GPS IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and require submission of a new IRB application or other materials to the GPS IRB. If contact with subjects will extend beyond **November 19, 2014**, a **Continuation or Completion of Review Form** must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research*:

*Policies and Procedures Manual* (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact me. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,



Thema Bryant-Davis, Ph.D.  
Chair, Graduate and Professional Schools IRB  
Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives  
Mr. Brett Leach, Compliance Attorney  
Dr. Judy Ho, Faculty Advisor

